THE lowdown

Health news, analysis and campaigns.
NUMBER 25, May 26 2020

Informing, alerting and empowering NHS staff and campaigners

Many CCGs already seeking cuts to tackle deficits

Get ready for £1bn squeeze

Too often CCG cuts have meant reduced access to care

As the remaining 135 Clinical Commissioning Groups (CCGs) throughout England begin to hold virtual meetings in public and publish Governing Body papers once again, it is becoming clear that many face daunting financial pressures.

Even the limited number of CCGs that have published up to date information show deficits from 2019-20 combining with historic underlying deficits to total almost £1 billion, even before the costs and dislocation of the Covid epidemic are included.

While many CCGs have either not met, or not published any up to date financial figures in the last few months, a quick snapshot survey of CCG websites by ***The Lowdown*** (May 25) has revealed at least 13 CCGs with deficits or underlying deficits in excess of £20m (and totalling £654m), including:

- Staffordshire and Stoke on Trent £76m,
- Cambridge and Peterborough £75m,
- Surrey Heartlands £62m,
- North West London £51m,
- Derby and Derbyshire £56m,
- North Central London on £46m,
- both North Yorkshire and Shropshire on £45m,
- and Cheshire on £41m.

Bristol, North Somerset and South Gloucestershire CCG (BNSSG), faces the biggest problems, with an accumulated debt of over £117m (approx. 5.9% of in year allocation) at the end of the 2019/20 financial year, according to its chief executive Julia Ross.

She has told local campaigners from Bristol Protect Our NHS that while hospital trusts have had a total of £13.4 billion of loans effectively written off, the same approach has not been taken with CCGs, and "NHS England has not published formal guidance for resolving their historic deficits."

These deficits seem certain to result in fresh efforts by CCG bosses to drive through additional savings, which we have seen in so many areas are likely to include "demand management" – restricting access to care.

There has been no increase in the core cash allocations to the NHS above the inadequate £33.9 billion promised by 2024

Pandemic funding

Extra funding has been promised to trusts and CCGs to cover the inflated costs of the epidemic itself; but it's not clear how long this will go on, and there has been no increase in the core cash allocations to the NHS above the inadequate £33.9 billion that the Johnson government has written into law by 2024.

This will go nowhere near the costs of getting the NHS back on an even keel, or tackling the massively rising waiting list.

NHS England's Operational and Planning Guidance for 2020/21 published in January did make clear that some of the larger CCG deficits (over 4% of allocated budget) could be reduced by up to 50% (on a case by case basis).

However this would be only on condition that

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IN THIS ISSUE

More plans for changes being hatched by CCGs

Under the radar

John Lister

Two weeks ago The Lowdown warned of plans being hatched by NHS England and local "Integrated Care Systems" (ICSs) and Clinical Commissioning Groups (CCGs) to force through far-reaching changes as soon as the lockdown period and crisis measures are eased off.

Many of these have been accepted with minimal discussion as emergency measures to deal with the Covid crisis, but which would be controversial as a permanent arrangement.

They include establishing a "new normal" of predominantly 'virtual' primary care and outpatient services, along with remote diagnostics, new approaches to triage, workforce models, use of volunteers, remote working, "pace and urgency to decision making," and new "financial models."

Cemented in

It seems that the changes accepted as temporary measures are already being cemented in. NHS England's plans in London make clear that to reverse away from any of these changes now requires the prior agreement of the Regional office.

NHS England have also begun to further cut back local accountability by establishing 18 so-called 'Integrated Care Systems' covering even wider catchment populations than most CCGs, but which are not public bodies, and are outside of existing legislation.

At the same time NHS England is encouraging the development of plans without any public discussion or scrutiny during the lockdown period, and "streamlined decision-making" – in other words minimal if any public consultation.

Scrutiny suspended

Even though the CCGs have continued to function behind the scenes, and some are meeting online while public attention is focused on the Covid crisis, it's clear that in many areas the local government and other bodies that should be scrutinising their plans and performance have been suspended, and are yet to get going.

After the prolonged dislocation of the purdah period prior to the general election, and the cancelled meetings and lockdown from March, many scrutiny committees will be months out of date, and face a deluge of densely-written documents when they eventually begin meeting again – especially where CCGs have been forging ahead with plans behind closed doors.

Insidious

Also during the lockdown the insidious growth of NHS England's reliance on the private sector has accelerated.

Private contractors and management consultants have been picking up lucrative contracts, often without competition or tendering, some at the discretion of the Cabinet Office rather than the NHS.

NHS England has been making it abundantly clear that they see the private hospitals playing a key role in restarting elective care, having block-booked up to 10,000 beds in private hospitals for the pandemic, few of which have been used, and many of which have now been released for the hospitals to treat private patients or NHS-funded elective treatment.

We know London faces big changes: how many other places?

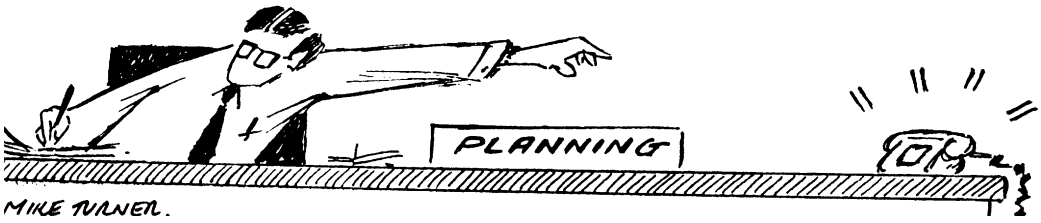
Essential

According to the ***HSJ*** these private beds are now seen as essential: "NHS trusts have been told to explain to the centre how they might best use private providers to achieve this goal. This intelligence will inform how and if NHSE might renegotiate the contract."

It is conspicuous that this focus on using private hospital beds comes at a point where tens of thousands of NHS beds are still closed.

Given the long-held wish of CCGs to scale down even further the numbers of acute hospital beds, the question must be whether, rather than when, many of them will be reopening in the foreseeable future.

While most eyes remain on the Covid-19 crisis, the challenge in many areas will be to keep track of far-reaching changes being implemented with little or no publicity or public consultation.



£1bn CCG cash squeeze

(from front page)

each CCG tackles the underlying issues that caused the overspends, to deliver in-year financial balance, and also sticks to the agreed repayments.

No help for biggest problems

In other words the CCGs with the largest deficits would have to make substantial cuts in spending in order to get any help at all, and those with deficits below 4% would get no assistance.

BNSSG is the biggest of the CCG deficits revealed so far, but far from the only CCG facing major financial pressures.

Of course CCGs that are preoccupied with cutting back on spending will not be able to respond to NHS England's stated desire to begin to reopen thousands of closed hospital beds and restart elective services, to begin the herculean task of reducing the bloated waiting list, which is estimated to top seven million by the autumn.

Care homes – Hancock's "protective ring" fails to protect

John Lister

As the scale of the disaster inflicted on our care homes and social care by the Coronavirus has become clear, and the scale of government incompetence, negligence and contempt for the care sector has been exposed, both Matt Hancock and Boris Johnson have made untruthful claims in an effort to cover up.

On May 13 Johnson told MPs "We brought in the lockdown in care homes ahead of the general lockdown." But extensive research by Reuters has produced no evidence of any such pre-emptive action.

Two days later Hancock made the now infamous claim that "right from the start we've tried to throw a protective ring around our care homes," claiming to have first set out advice in "February". But in fact as Keir Starmer had pointed out in exchanges with Johnson, the government claimed right up to March 12 that it was very unlikely care home residents would be infected.

Hancock's implausible claims have been repeatedly and systematically refuted ever since, by a succession of care home staff and managers, notably in a series of reports on the BBC's Newsnight and a major investigation on File on 4.

Prioritise emptying hospital beds

They have explained how badly they have been and are still being let down, both by government and by local NHS trusts, which followed NHS England instructions to prioritise emptying thousands of hospital beds to prepare to cope with for Covid patients – even at the expense of further spreading Covid infection into vulnerable care homes.

Among the less likely, but more vocal critics revealing the facts that undermine Hancock's claims, has been the ***Daily Telegraph***, with a toughly-worded feature from its Economic Intelligence section on May 12 Government's handling of Covid-19 is a very British disaster. It quotes at length from a cardiologist at a top London hospital – "friendly to Boris:"

"Our policy was to let the virus rip and then 'cocoon the elderly'," he wrote. "You don't know whether to laugh or cry when you contrast that with what we actually did.

"We discharged known, suspected, and unknown cases into care homes which were unprepared, with no formal warning that the patients were infected, no testing available, and no PPE to prevent transmission.

"We actively seeded this into the very population that was most vulnerable."

Aggrieved NHS trust bosses, angry at carrying the blame for policies imposed from the top down by government and by NHS England, have now, through NHS Providers produced an attempt to refute "the suggestion that they 'systematically' and 'knowingly' transferred known COVID-19 patients into care homes."

In doing so they underline the hollowness of Hancock's and Johnson's claims to have done the right thing from the beginning.

They confirm that it was only on March 13 did initial guidance from Public Health England (PHE) "encourage residential care homes to review their visiting policy, asking people not to visit if they were unwell and emphasising hygiene measures."

Just a few days later on March 17, NHS England and NHS Improvement instructed trusts to "urgently discharge all medically fit patients from hospital as soon as it was clinically safe to do so."

The target was to free up 15,000 acute beds this way … in just ten days. Many were returned or dfischarged to care homes.

Two weeks later the Department of Health and Social Care published guidance (April 2) which insisted that patients with COVID-19 – whether symptomatic or asymptomatic – could be safely cared for in a care home setting, and that negative tests were "not required prior to transfers/admissions into the care home."

Only on 15 April did the government's Adult social care action plan say trusts would need to test every patient prior to discharge – whether they had symptoms or not.

NHS Providers now argue that "Trusts were already testing patients and care home residents with symptoms" – but accept this was only done "wherever testing capacity allowed."

Two months after instructing hospital trusts to speed through the discharge of patients came new NHS England guidance to test all patients being discharged to a care home up to 48 hours before discharge. By then the damage had been done.

Care home COVID deaths have been running at over five times the numbers in hospital – where thousands of beds are still empty

Nothing to protect care homes

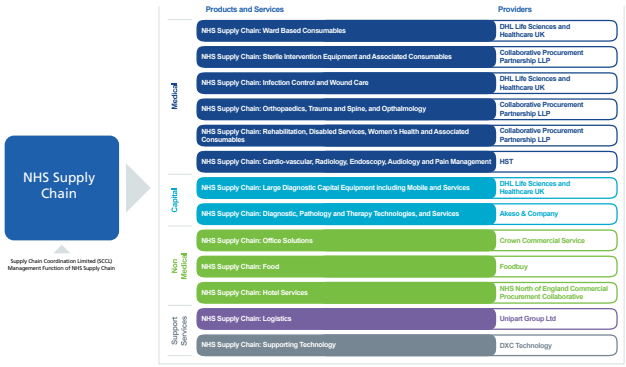
So NHS Providers may have a case when they argue that trusts did not "knowingly" or "systematically" discharge COVID infected patients to care homes: but neither did they do anything to protect the care homes from the disaster that has occurred.

Care home managers have been telling of the bullying and moral blackmail of trusts sending ambulance crews with patients to demand the care home accept them back to "their home."

And they have been telling of the consequences. Two of the largest care home chains have had over 1,000 COVID-linked deaths (HC-One) and over 500 (Four Seasons): care home COVID deaths have been running at over **five times** the numbers in hospital – where thousands of beds are still empty.

At the last count ONS figures show over 26,000 care home deaths involving COVID-19 since the middle of April, not including care home staff. If that's Hancock's "protective ring" at work, it's not very impressive.

The "privatised," "dysfunctional" system that led to the PPE crisis



Sylvia Davidson

When the Covid-19 pandemic struck, the NHS was unprepared due to its "heavily privatised, convoluted, and fundamentally dysfunctional system" of product supply, in particular of personal protective equipment (PPE), according to a report published by the Public Services International Research Unit at the University of Greenwich and the campaign group We Own it.

The report follows up an earlier report at the end of March in ***The Lowdown***, highlighting the role of Unipart in the heavily privatised system.

The government's privatisation of the supply chain, notes the report, led to the disastrous failings in getting adequate PPE to where it was needed as the number of coronavirus cases rose. This ultimately may have led to the deaths of NHS workers.

There has been an outcry in the press over the lack of PPE, however the report notes that little has been said about the role of privatisation on the shortages.

The production and supply of goods to the NHS, including all PPE equipment, is very complex and for the most part in the hands of private companies. This is a result of several years of privatisation of the NHS' procurement and logistics system under the guise of efficiency savings.

In 2018, NHS Supply Chain was created and then in April 2019 Supply Chain Coordination Limited (SCCL), was created by the Health Secretary, Matt Hancock, supposedly designed to be a company to take on "the in-house management function of the NHS Supply Chain".

Both NHS Supply Chain and SCCL are ostensibly still part of the NHS, but what followed their creation was the awarding of a complex web of contracts and sub-contracts to private companies. Companies include DHL, the parcel delivery company, and Unipart.

Four levels of profit taking

The complexity of the set-up - the report notes that "every piece of equipment passes through four levels of profit-taking before it arrives at the hospital" - has taken control further and further away from government.

This lack of central control and removal of civil servants from the process, the researchers argue, has weakened governance and made it very difficult to manage unexpected events, such as an epidemic. As a result, the national effort to protect NHS and care workers has been "severely undermined."

When the pandemic started and the need for more PPE became evident, companies and organisations across the country were offering help, yet many found "no one in government willing to take their call", note the researchers.

The UK has known for sometime how important it is to stockpile for the possibility of an epidemic and to create secure supply chains, however the privatisation that has taken place has severely undermined this fundamental approach to preparedness for unexpected events, notes the report.

Instead, privatisation of the supply chain has generated "perverse incentives that encouraged a rationing of the demand for PPE, rather than a boosting of supply". As a result, as the pandemic escalated, NHS trusts had to find ways to source PPE themselves as the stockpile and secure supply chains were just not there.

Privatisation, the report notes, is also the reason why this measure - desperate NHS trusts forced into sourcing their own PPE - has been stopped.

If the pandemic had not happened, the privatisation of the supply chain and its effect on the NHS, would not have been brought to the public's attention

Protecting profits

On 3 May 2020 the government told trusts to stop buying their own PPE equipment and said that SCCL should take over the management of any new deals being negotiated between trusts and suppliers. The report suggests that the reason for this is SCCL protecting the private companies that it deals with:

"They [SCCL] are protecting their own contracts with other private companies, and literally managing demand to fit the supply, rather than responding to demands from the NHS for resources."

The report argues that the privatisation of the supply chain has also led to the ethos of 'just-in-time' production being introduced into the NHS. This system, probably best-known from the manufacture of cars, results in very little inventory being stored and acts to minimise waste.

Unfortunately for NHS health workers around the country, use of such a system within the NHS, means that the supply system cannot respond to unexpected events.

This, the report notes, is the opposite of what is needed in NHS supply chains. What is needed for public health systems is "sufficient give and flexibility in the system" otherwise there are insufficient key supplies available for unforeseen exceptional emergencies - "a nightmare of inadequate stocks just when they are most needed."

If the pandemic had not happened, the privatisation of the supply chain and its effect on the NHS, would not have been brought to the public's attention, notes the report. Now it has surfaced, however, there is a need to take action urgently.

Prioritise safety

What is needed is an NHS Supply Chain that puts "people before profit, which takes responsibility instead of abdicating it, and which prioritises long-term planning and community safety."

In effect "a simpler system under direct NHS control, with clear lines of accountability and a culture of prioritising safety, long term planning and smart use of skills and resources within the NHS and in local communities and the local manufacturing sector."

The authors of the report, who include ***Lowdown*** co-editor John Lister, also call for a public inquiry into the government's handling of the PPE crisis.

■ The full report - ***Privatised and Unprepared: The NHS Supply Chain*** - is available at: weownit.org.uk/privatised-and-unprepared-nhs-supply-chain

Please support campaigning journalism, to help secure the future of our NHS





Dear Reader
Thank you for your support, we really appreciate it at such a difficult time.

Before Covid 19 the NHS was already under huge pressure and, after it's all over there will be a backlog of patients, queues of people affected by the crisis, and a hugely tired workforce.

From that moment we will need a much more credible plan to fund, support and protect our brilliant NHS. Our goal is to help make this happen and we need your help.

We are researchers, journalists and campaigners and we launched ***The Lowdown*** to investigate policy decisions, challenge politicians and alert the public to what's happening to their NHS.

It is clear from the failures of recent years that we can't always rely on our leaders to take the right action or to be honest with us, so it is crucial to get to the truth and to get the public involved.

If you can, please help us to investigate, publicise and campaign around the crucial issues that will decide the future of our NHS, by making a donation today.

Our supporters have already helped us to research and expose:

- **unsafe staffing levels** across the country, the closure of NHS units and cuts in beds
- **shocking disrepair** in many hospitals and a social care system that needs urgent action, not yet more delays
- **privatisation in the NHS** - we track contracts and collect evidence about failures of private companies running NHS services.

First we must escape the Covid crisis and help our incredible NHS staff.

We are helping by reporting the facts around the lack of protective equipment for hospital staff but also for thousands of carers.

We are publishing evidence about more community testing and the shortcomings in our strategy to beat the virus.

Even though they have a tough job, there have been crucial failings: on testing, PPE and strategy and we must hold our politicians and challenge them to do better.

We rely on your support to carry out our investigations and get to the evidence. If you can, please make a regular donation, just a few pounds a month will help us keep working on behalf of the public and NHS staff - thank you.

We all feel such huge gratitude and respect for the commitment of NHS staff and it's so impressive to see such strong public support. Let's hope that we can give the NHS the thanks it deserves and crucially, secure its future.

With thanks and best wishes
from the team at the ***Lowdown***

Every donation counts!

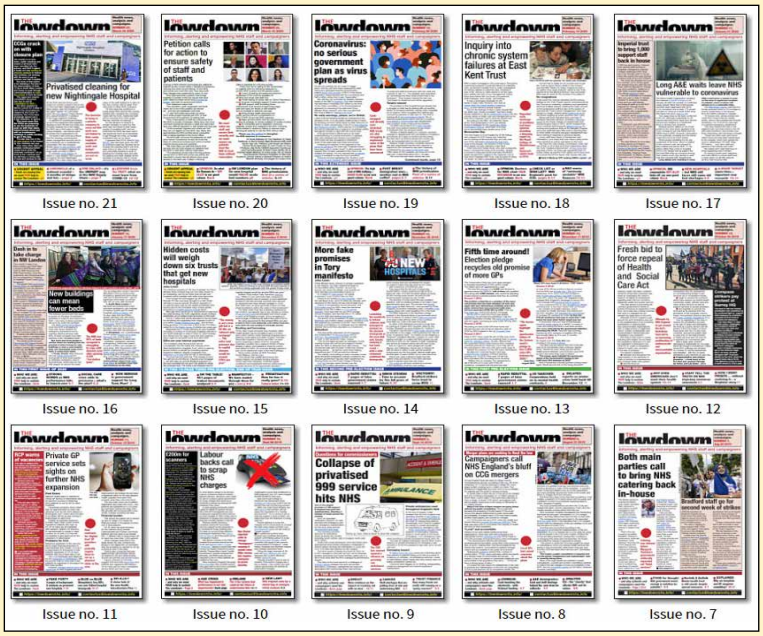
We know many readers are willing to make a contribution, but have not yet done so.

With many of the committees and meetings that might have voted us a donation now suspended because of the coronavirus, we are now asking those who can to give as much as you can afford.

We suggest £5 per month/£50 per year for individuals, and at least £20 per month/£200 per year for organisations: if you can give us more, please do.

Supporters can choose how, and how often to receive information, and are welcome to share it far and wide.

● Please send your donation by BACS (54006610 / 60-83-01) or by cheque made out to NHS Support Federation, and post to us at Community Base, 113 Queens Road, Brighton, BN1 3XG



● If you have any other queries or suggestions for stories we should be covering, contact us at *contactus@lowdownnhs.info*

Track and trace failings risk safe release from lockdown

Sylvia Davidson

The easing of the lockdown and a safe return to school for hundreds of children and their teachers is dependent on an effective test, track and trace programme. Over the past few weeks deadlines for the system have slipped from mid-May to 1 June, then suddenly Matt Hancock announces its launch at 9am today (28 May) and exhorted every person to do their "civil duty" and stay at home when instructed.

Questions have been raised about the suddenness of the launch and the reasons for pulling it forward, but Matt Hancock in an interview with Kay Burley on Sky News, denied that the government has rushed in the system to take the spotlight off Dominic Cummings and his failure to follow lockdown rules.

The track and trace system involves 25,000 contact tracers phoning people who test positive for the virus and being asked for the names and phone numbers of family, friends and colleagues whom they have been within 2 metres of for more than 15 minutes within the previous two days. The tracer will then phone these people and tell them to self-isolate for 14 days and remove children from school.

Whether an effective track and trace system is actually ready for launch is in question, however.

For a start the system will be without the app, which is currently still on trial in the Isle of Wight.

Boris Johnson at Prime Minister's questions 20 May said "a test, track and trace operation that will be world-beating….will be in place by 1 June". But just a few hours later, Downing Street confirmed that the NHS smartphone app, an integral part of the track and tracing operation, would not be ready for 1 June.

Adding to the doubt, Justice Secretary Robert Buckland admitted the test and trace system would not be "as widespread as we'd like" by June.

Privateers recruited

Without the app, the system launched by Matt Hancock relies on more traditional contact tracing; thousands of people physically picking up a phone and tracking down the contacts of those who have reported Covid-19 symptoms and/or have tested positive. This is a labour intensive business requiring thousands of people, however reports over the past couple of weeks throw into doubt whether the contact tracing programme is ready to be launched.

Recruits are expected to show empathy and demonstrate "communi-cation skills", but will only receive one day's worth of remote training

Earlier this year under emergency procurement rules, Serco was awarded contracts to recruit the vast majority of 25,000 contact tracers, with Capita also responsible for a few thousand. After some confusion about how many contact tracers had been recruited, it seems that at least 21,000 have now been recruited.

Contact tracing is a skill, and training is required. The recruits are expected to show empathy and demonstrate "communication skills", but will only receive one day's worth of remote training, involving classroom-style teaching. However, even this small amount of training is reportedly proving difficult to achieve. The Guardian reports that people are spending days trying to just log in for virtual training sessions. One person told the Guardian that when they were on a training session, run by contact centre company Sitel, they asked for guidance on how to speak with somebody whose loved one had died of coronavirus, they were reportedly told to look at YouTube videos on the topic.

New contact tracers will work on a call centre model and have been told to rely on a two-page script and a list of frequently asked questions, reports the Guardian. The contact tracers are expected to refer specialist queries to a separate team of 3,000 medics or senior nurses.

Both Serco and Capita have a difficult history of working in the UK public sector - Serco was fined by over £19 million last year by the Serious Fraud Office for its part in defrauding the government over electronic tagging. Capita's running of the NHS Primary Care Support Services contract has been the source of numerous complaints and the company has now had part of the contract, for cervical cancer screening, removed.

Serco has already had to apologise for accidentally sharing the email addresses of 300 contact tracer recruits - an error that could be referred to the Information Commissioner for investigation.

This form of contact tracing will be bolstered by

the app, when this is ready. The app being developed by NHSX, the Department of Health and Social Care's technology department, is currently being piloted on the Isle of Wight. It uses Bluetooth technology to detect and alert people who might have come into contact with those infected with the virus and requires at least 60% of the population to report their health status to be effective.

App hazard

The app has received considerable criticism. At the start of May, just prior to its launch, HSJ reported that the app had failed all of the tests required for inclusion in the NHS app library, including cyber security, performance and clinical safety. Despite this it was rolled-out 7 May on the Isle of Wight.

The app uses Bluetooth technology to register a "contact" when people come within 2 m of each other for at least 15 minutes. If someone develops symptoms of coronavirus they inform the app and an alert will be sent to other people they have been in close contact with.

Soon after its launch, glitches were being reported, including that it doesn't work on older phones and NHSX said that it was working to iron out problems,.

Concerns are also being raised around the app's privacy and information governance. The government has insisted on deploying a centralised tracing database, which records a user's contacts and the first half of their postcode if they declare they are ill.

This is at odds with the approach taken by Apple and Google, who say contact data should be retained only by a person on their phone. A major issue is that unlike contact-tracing apps under development elsewhere in Europe, the UK version does not incorporate new Google and Apple technology to improve the Bluetooth function.

Scammers have already targeted the app. The Chartered Trading Standards Institute (CTSI) reports that it had received evidence of a phishing scam themed around the app. A further embarrassment came when the tech publication Wired reported that a considerable number of documents on the app's development had been left open to the public via a google drive link.

Councils are being kept in the dark and fear trace and trace will be a "shambles" on the same scale as personal protective equipment (PPE) and Covid-19 testing.

Criticism

The government's approach to track and trace has been criticised by some senior directors of public health, according to a report in the Local Government Chronicle. They report being kept in the dark and fear it will be a "shambles" on the same scale as personal protective equipment (PPE) and Covid-19 testing. They also note that they have not been involved in co-designing the track and trace programme despite what the Whitehall press briefings might say.

On Twitter, Kate Ardern, Wigan MBC's director of public health, tweeted: "You cannot expect people with no appropriate background knowledge, skills or experience to do this vital job with little training or expert supervision... contact tracing is a skilled job!"

Contact tracing is not a new thing; it is regularly carried out by highly trained personnel in public health departments, which puts these departments in an ideal position to help Serco and the other private companies, you'd have thought.

However, one public health director told LGC that not a single document about the work of Serco had been shared with them during national calls and they were under the impression that government officials "do not yet know themselves" how Serco's work would be joined up with that of local government.

More positively though, the government has shown more willingness to get local government involved with the appointment of Tom Riordan, Chief Executive of Leeds City Council as national lead on tracing.

Opposition proposals

The Labour Party has put forward its own ten proposals for an effective "test, track and protect system" in a letter from Jonathan Ashworth to Health Secretary Matt Hancock. The proposals for track and trace include allowing local government directors of public health to lead on contact tracing, the recruitment of more contact tracers; clear public communication; and work with tech companies to show greater flexibility developing an app.

The government row with unions and teachers over whether it was safe to restart classes continues. The BMA, the largest doctors' union, backed the teaching unions. in a letter to the National Education Union on 15 May that the number of coronavirus infections remained too high to allow them to run safely. It said teaching unions had been "absolutely right" to urge caution and prioritise testing before reopening schools on 1 June.

Finally at the press briefing 20 May, Robert Buckland, the justice secretary, conceded that not all schools would be able to open on 1 June. At least 11 councils are refusing to reopen their schools.

Ultimately the success of the test and trace system rests with how high compliance is and this is bound up with how much people trust the system and the government. Commentators think that such compliance is now unachievable following the revelations that Boris Johnson's adviser Dominic Cummings has broken lockdown rules.

Shadow Health Secretary Jonathan Ashworth told Good Morning Britain "lots of people who are asked to stay home for two weeks with no symptoms will think why is it one rule for us and one rule for Dominic Cummings?" He believes that the government's defence of Cummings could affect the test and trace programme.

Mental health – the poor relation

Mental Health Awareness Week, pushing for wider community support for people severely affected by mental illness, has just ended. Its message may have got lost amid all the talk of reduced infection rates and the economic impact of the lockdown, but the Department of Health and Social Care still decided to jump on board with a few headline-grabbing cash grants to mental health charities.

But those awards – worth just £4.2m – will have little impact on the wider provision of mental health services, already creaking under the strain of cuts to NHS and local authority budgets and now struggling to cope with the added burden of rising demand driven by the pandemic.

In fact charities are themselves stepping up to provide 24/7 mental health support to frontline care workers during the Covid crisis, as Mind, the Samaritans, Shout, Hospice UK and The Royal Foundation come together to launch a range of services under the Our Frontline banner.

So what would really make a difference to the state of mental health services in the UK, during the pandemic and beyond? Adequate funding is the only answer, rather than an increasing dependence on charitable activity.

There's no getting away from the impact of ten years of budgetary constraints on health provision in the UK. Consider for example the fate of child and adolescent mental health services (CAMHS), the recipient of less than one per cent of the overall NHS budget.

Cancelled appointments

In November 2019, Mind released figures showing that in the previous 12 months the NHS in England cancelled 175,000 CAMHS appointments – 25 per cent more than in the previous year. And last month the charity revealed that almost a quarter of people who tried to access mental health support over two weeks during the lockdown had failed to get any help at all.

This tightening of eligibility criteria was confirmed by a recent Pulse survey of GPs in which nearly 30 per cent said the rules governing CAMHS referrals had become stricter, with only one in five NHS mental health trusts now accepting appointments.

It's surely no coincidence that the number of A&E attendances by young people with a recorded diagnosis of a psychiatric condition has almost tripled since 2010. Or that an increasing number of GPs are now advising parents to seek private mental health care for their children.

Current funding and staffing levels – and the number of beds available – across the mental health sector generally don't help. Last month The Lowdown found that mental health services only received 13 per cent of the overall NHS budget despite accounting for 23 per cent of the disease burden, and that a fifth of mental health trusts saw a drop in income.

In November 2019, Mind released figures showing that in the previous 12 months the NHS in England cancelled 175,000 CAMHS appointments

The staffing statistics were no better: in 2013 there was one mental health doctor for every 186 patients accessing services, and one mental health nurse for every 29 patients. By 2018 those figures had dropped to one for every 253, and one for every 39, respectively. No surprise really, given that – in 2017-18 alone – 23,686 mental health staff left the NHS.

Those stats showed that the number of mental health beds has also slumped, by nearly 3,000 since 2013, leading to local issues of availability.

In November last year the Royal College of Psychiatry (RCP) published a report claiming that, to offer appropriate levels of care to patients in their local community, more than a thousand extra mental inpatient beds were needed.

Inpatient mental health care is also suffering from a poor 'estate'. In its 2014-17 report on the sector, the Care Quality Commission found that many mental health wards were unsafe, but earlier this year NHS Providers noted that only three out of 20 mental health trusts were allocated funding in the first – and none in the second – wave of capital investment announced by the government last September.

Substance abuse under lockdown

So that's the history. To assess how past decisions on funding might continue to play out in the current crisis, let's focus on another area of mental health, of particular relevance during the lockdown. Substance abuse.

High street sales of alcohol leapt by 22 per cent in March as people prepared for the lockdown, prompting a joint statement from the Alcohol Health Alliance and the Commission on Alcohol Harms warning of "the toll of increased alcohol harm for a generation" to come. And the Guardian recently reported that vulnerable drug users were turning to dangerous alternatives such as heroin because of a pandemic-related shortage of synthetic cannabinoids like spice.

But this comes after local authorities – responsible for the delivery and funding of alcohol and drug addiction

services since 2012 – had to reduce their spending on those services in 2018/19 on average by £155,000, despite soaring levels of hospital admissions due to alcohol abuse.

Budget cuts collectively amounting to £2.4m for child addiction services were also imposed on councils in England last year.

More generally, after eight weeks into the lockdown the RCP warned that health services could be overwhelmed by "a tsunami of mental illness", as people start to develop serious psychological problems for the first time.

And despite the restricted access to CAMHS appointments mentioned earlier, there has been a pandemic-related drop in referrals in recent weeks. The Birmingham Women's and Children's NHS Foundation Trust has seen a 50 per cent reduction in referrals since March.

Virtual care

Most people's experience of accessing mental health care during the pandemic is now via computer or phone. Introduced to ease the pressure on hospitals and GP surgeries while reducing transmission of infections, this policy is proving to be no substitute for talk therapies, group workshops and other outpatient services now deemed inessential.

Guidance from the RCP suggests patients can find it uncomfortable to discuss personal matters at a distance, particularly with a doctor or therapist they've not met in person before, and the college advises that not everyone has access to digital technology.

The RCP's stance is borne out by the experience of one community mental health nurse, who agreed to talk to ***The Lowdown*** last week, on condition of anonymity:

"All but urgent face-to-face patient visits have been replaced by phone contact," she told us.

"I haven't seen a patient in person since March. This is a real change from pre-covid when around 80 per cent of the treatment I provided would have been face-to-face. Video consultations are possible for those with the tech skills, equipment, privacy and mental capacity needed, but most of my patients can't manage this."

Many of those patients are elderly and live alone. For some the only human contact they have is health appointments, so isolation is having a really detrimental effect on them. "I'm glad we can still call patients and make contact that way – sometimes they tell me they haven't spoken to anyone all day," she explained.

Missing markers

"What we cannot see, though, is whether they are really coping. If someone has got washed and dressed, if there's evidence of eating or having food in the cupboards – these are markers of mental health that cannot be assessed over the phone.

"Similarly, the nuances in conversation, eye contact and expression, which are all used to assess someone's wellbeing, cannot be done over the phone either, so it feels that we cannot identify risks [such as self-harm] as accurately now."

"As a practitioner I also feel more isolated from my team while working from home. We have daily Skype check-ins," she added, "but they cannot replace the conversations that happen in a shared workspace that allow for a different perspective on a situation.

"And there's now a possibility that community mental health teams may start to get referrals for traumatised hospital staff or people who've recovered from covid-19.

"I do feel under extra stress because of the pandemic. I have patients on my caseload with serious mental health problems, who I'm responsible for, who I've never met face-to-face. I cannot fully assess them or their living situation, or tell how well they are coping, yet the buck will stop with me if anything happens."

The IPPR report claims the covid outbreak is having a severe impact on the mental health of NHS staff, often through worrying about their ability to ensure patient or service-user safety

Enforced isolation

Two points made by this nurse – about the enforced isolation from her colleagues, and the possibility she may soon get referrals from traumatised hospital staff – flag up the impact the pandemic is having on the mental health of NHS staff, and the inadequate support they may be getting.

Last month [April] the Institute for Public Policy Research (IPPR) launched its 'Care fit for carers' report, which claimed the covid outbreak was having a severe impact on the mental health of NHS staff, often through worrying about their ability to ensure patient or service-user safety because of a lack of testing and personal protective equipment.

The IPPR noted that many patient-facing healthcare professionals are not eligible for bespoke therapy, and urged the government to address this situation – currently, it is only available to doctors and dentists.

That perhaps brings us finally on to health secretary Matt Hancock's claim at the end of April that mental health support services were being "restored".

This was a surprise to many working within the sector, who were quite certain that mental health services had never actually shut down.

But his statement also begs the question – given the ever-present threat of privatisation, and the prospect of virtual consultations becoming a more regular part of healthcare in the future – of what might be left of this vital part of the NHS to restore, once the pandemic is over…

From Nightingale to Nightmare – how journalists undermined a PR stunt

This is a chapter by JOHN LISTER that has just been published in The Virus and the Media, a new book in which a distinguished cast of journalists, commentators and academics have each written articles on their understanding of how well journalism – online, broadcast and print – has presented what has happened to the public.

It all appeared to be going splendidly. The news media latched on to the scale of achievement of converting the massive ExCel conference and exhibition centre into a huge "NHS Nightingale" field hospital with up to 4,000 beds in just nine days.

The irony that Florence Nightingale's fame was as a nurse struggling to save the casualties of Britain's disastrously bungled war in Crimea was overlooked.

With ministers apparently emulating North Korea's public relations style rather South Korea's prompt and effective public health measures to contain the virus, this seemed a brilliant way to distract journalists away from any scrutiny of embarrassing questions.

These include the dire shortage of hospital beds driven by ten years of frozen NHS budgets, Britain's poor level of provision of intensive care beds and equipment compared with similar countries in Europe, the desperate shortage of nursing and medical staff, the lethal lack of personal protective equipment (PPE) and incompetence distributing it, and ministers' failure to act on previous warnings of gaps in readiness to cope with a pandemic.

Some media reports even compared the rapid completion of the reconfiguration of the London Nightingale with the massive Chinese effort in Wuhan, which involved clearing land and building several vast prefabricated hospitals from scratch in just ten days.

On Friday April 3 when Prince Charles opened the new London Nightingale field hospital by video link all the news headlines were about the great effort that had been made.

Print and broadcast media regaled us with awkward photographs of the grand occasion, with England's Health Secretary Matt Hancock standing proudly as the Great Helmsman at the forefront of a line-up of staff, spluttering into his handkerchief after self-isolation with suspected Covid-19.

Who would have guessed that just a month later, with British death levels the highest in Europe, the hospital would have closed, with much less pomp and circumstance? It had actually used just 42 of its potential 4,000 beds, and barely touched much of the new equipment that had been supplied. At the peak of Covid admissions over Easter weekend, the London Nightingale only had 19 patients.

NHS England bosses had to tour London's hospital trusts demanding CEOs take staff from their work and dispatch them to join the team at the ExCel centre in Newham

Limiting factors

The whole stunt swiftly unravelled. Despite fanfares for the discharge of the Nightingale's first cured patient, the more astute journalists from left and right have continued to point out that two limiting factors have doomed this and the other nine Nightingales from the outset.

The first and potentially the most crucial is the chronic lack of staff: even in the final few days before it was closed (AKA "on standby," or "mothballed" in readiness for a second surge) NHS England bosses had to tour London's hospital trusts demanding CEOs take staff from their work and dispatch them to join the limited team at the ExCel centre in Newham. Where sufficient volunteers could not be found, reluctant trust bosses were required to select staff and dispatch them.

Most in demand were the very intensive care (ICU) nurses – who were most needed in their own hospitals. Even the less sophisticated anaesthetic ventilators – the main type installed in the Nightingale – required experienced staff to make proper use of them.

Attracting staff became harder when some early volunteers came back to tell of the frustration of treating a small handful of patients in a large soulless building with an excess of doctors and nursing staff, knowing the pressures on their colleagues back at their own trusts. At the end 200 staff were on duty on May 4 to look after just 12 Nightingale patients.

Journalists also began to highlight the second limiting factor, the confusion over the role of the new hospitals. Although it was billed as offering expanded ICU capacity, admission criteria for the London Nightingale appear to exclude patients requiring full ventilator treatment (any patient scoring above five on the clinical frailty scale). Any patient with significant complications or serious intensive care needs such as renal replacement therapy, or filtering blood in place of the kidneys, was excluded.

Hospitals left with sickest

London hospitals, which had expanded ICU provision in existing hospitals (often by converting operating theatres into makeshift ICUs) were left to treat the sickest patients. They somehow coped with the

Magnificent – but empty: the North East Nightingale in Washington, Tyne and Wear, on May 4, just before its brief opening

demand, but hospital trusts in and outside London became even more resistant to NHS England pressures to refer patients to the London Nightingale.

A detailed Independent report was the first to explore the problem in depth: the hospital had too few patients to justify its existence… but too few staff to take any more. It also lacked any surgical facilities, so was not able to offer any additional capacity to treat the growing waiting list of patients waiting for elective operations. It was neither fish nor fowl.

As David Rosser, chief executive of University Hospitals Birmingham NHS Foundation Trust said of the Birmingham unit: "Is it as good as a bed in a hospital? No, not by a long stretch. It remains fundamentally a warehouse with beds in it."

Local news media also began to criticise the nine additional Nightingale-style hospitals created at huge expense elsewhere in Britain, none of which have had more than a handful of patients.

Birmingham's Nightingale in the National Exhibition Centre (NEC); Manchester's Nightingale in the main hall of the former Manchester Central Conference Centre; the Harrogate Nightingale in the Convention Centre (opened by Captain Tom Moore) and Bristol's Nightingale hospital at the University of the West of England between them had up to 4,000 beds. Almost none of them were used.

The North East Nightingale in Washington's 'Centre of Excellence for Sustainable Advanced Manufacturing' barely even opened, and a Nightingale hospital in a former Homebase store in Exeter didn't open at all.

Devolved administrations followed the Westminster line, with the 2,000 bed Dragon's Heart Hospital at Cardiff's massive Principality Stadium becoming the second biggest white elephant after the London Nightingale.

Only in Belfast was a hospital building used – converting City Hospital's tower block into a 230-bed unit.

And only the NHS Louisa Jordan at the Scottish Events Campus (SEC) in Glasgow (named after a Scottish nursing heroine who died in the first world war) has been publicly costed, offering up to 1,000 beds at a cost of £43m, even though Scottish ministers were relatively confident it would never be needed. It wasn't.

More questions are now being asked, as the PR triumph backfires. While the London and Birmingham hospital sites have been made available rent free, it's not clear how much has been spent on the Nightingales.

But while the makeshift hospitals have done little or nothing for patients, the new hospitals have improved the health of balance sheets for private contractors including KPMG, Mott McDonald, Archus, and Interserve who were given contracts without competitive tendering under pandemic procurement rules.

It's not just the building work that has offered profitable contracts: support services were also contracted out. ISS were brought in to clean and dispose of waste at the London Nightingale and G4S was given the contract for security at all ten Nightingale hospitals.

Private hospitals

Fewer questions have so far been asked about the wisdom of NHS England paying an estimated £300 per bed per day to use 8-10,000 beds in private hospitals, most of them small buildings lacking any ICU capacity and geared only to uncomplicated elective surgery. But the Daily Mail reports large numbers of these beds are also standing empty, no doubt because of their limited usefulness and underlying shortages of qualified staff.

Indeed there is growing media concern over the 40% of acute hospital beds (37,000) left silent and empty after 33,000 patients were hurriedly discharged and almost all NHS elective treatment halted to clear space for potential Covid-19 patients.

However ONS figures have now revealed how many thousands of these people have instead been dying without NHS care, especially after untested patients were sent home or dumped (under emergency legislation) into residential care and nursing homes.

The real cost of the Nightingales won't be measured in cash terms but also in lives shortened or lost among non-Covid patients as staff and resources were misdirected into useless vanity projects.

While front line staff have been left frustrated and idle in Nightingale hospitals, fear of Covid-19 infection has apparently deterred huge numbers of patients from seeking emergency treatment.

Thousands of stroke and heart patients have stayed away from A&E departments, while NHS England as recently as the end of April was insisting on the "paramount" need to free up beds usually occupied by stroke patients … to care for those suffering from coronavirus.

Some reports have highlighted frightening projections of thousands mopre deaths as millions of outpatient appointments have been cancelled and many hospitals cancelled all cancer surgery.

The Royal College of Surgeons are warning that it could take five years to clear the "mountain" of a waiting list that was rising even before the Covid crisis

The Royal College of Surgeons are warning that it could take five years to clear the "mountain" of a waiting list that was rising even before the Covid crisis.

So while it all started well for ministers, it has ended badly for patients and staff – slumping from Nightingale to Nightmare in just one month.

Too many inquisitive journalists have meant government efforts to spin their way out of a pandemic have ended in tears.

The Virus and The Media, How Journalism Covered the Pandemic is available now as a download from Amazon, or from Bite Sized Books.

Roy Lilley's unpublished call – to nationalise care homes

Something I said

The Telegraph asked me to write a piece about care homes. In the end, the article was spiked... never used. However, I don't see why you shouldn't read it, if you want to, so, here it is...

There was an unusual event at Prime Minister's questions yesterday. Not just that you could hear the questions and people seemed really interested in the answers.

No, it was Boris Johnson' s stark confession that there was a Covid-crisis in our care homes.

Blunt admissions of failure are rare pieces of parliamentary theatre.

He is right. Based on figures from the Office of National Statistics, from 10-24 April, there were 4,343 deaths involving CV-19 in care homes. There looks (then) to be no sign of these numbers abating.

Are care homes the last place for Granny to be cared for?

Part of the answer is that many care homes can't care. It's not that they don't care. They just don't know how to care in a crisis such as this. They are not nursing homes.

Staffed by hard working, well intended people, often, working on minimum wages, with English not their first language. With only basic care and health and safety training and from the outset, scant protective equipment, they stood no chance.

Without nursing input or medical advice, infection control techniques are not routinely taught.

Taking basic observations, like oxygen-saturation tests, a sure sign of infection, are rarely carried out and care home operators are left, as spectators, watching CV-19 rip through their vulnerable residents.

Is it too much to describe them as death traps?

The situation was exacerbated when it was decided, to make room for Covid-cases, elderly patients should be discharged from hospital, into care homes, without a routine CV-19 test. The consequences were like throwing petrol on a fire.

Did government abandon care homes to their fate, or was there a reasonable expectation that home operators, paid to care, would have some element of preparedness and be able to do their job.

Epidemic plans, resilience, basic reserves of protective equipment, infection control, barrier-care and arrangements for staff testing. Food delivery company Ocado and Amazon test their staff, why should care homes not be responsible under health and safety regulations and also test?

The government discovered, too late, the care home sector is as fragile as their residents and powerless to stop the contagion.

The care home market has around 473,000 beds, mainly small operators, working on slim margins. About 14%, run by five bigger companies.

One of the biggest, HC1, operates 22,000 beds. The executive chairman is Sir David Behan, formerly the boss of the Care Quality Commission and now chair of Health Education England and associate board member of NHSEngland.

It is reported, two-thirds of his care homes are owned by sister companies in Jersey and the Isle of Man and the provider's operating company, HC-One Ltd, made a £6.5m loss in 2018 but paid out an estimated £40m in rent to offshore firms.

This points to a fragmented market in need of consolidation and better regulation for the bigger operators. The other solution is to do what Bevan did, in 1948, to pull together the broken health sector. He nationalised it and called it the NHS.

Nationalise the care home market, create the National Care Service and pay for adult social care like we pay for the NHS, through our taxes. Simples.

Successive governments have neglected care homes. In 1997, new Labour's Health Secretary, Frank Dobson promised a Green Paper on the future of adult social care. Since then, time and again, governments have failed the challenge.

Two years ago I asked Health Secretary Matt Hancock when we could expect a green paper on adult social care. April, was his answer. Alas, I neglected to ask which year.

It will be Boris Johnson's government that will pay a heavy price for the historic neglect of the care home sector. The assumption that care homes could cope will cost him dear.

Johnson was honest about the problem. Can he be truthful about the solution?

The Telegraph were very courteous about not using my efforts and thanked me. They gave me no reason for rejection... maybe it was something I said!

The other solution is to do what Bevan did, in 1948, to pull together the broken health sector. He nationalised it and called it the NHS.

● You can sign up free for Roy Lilley's e-letter at https://ihm.org.uk/roy-lilley-nhsmanagers/